FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019489

Facility Name: Manorcare at Westmont

Address: 512 East Ogden Ave. (Number) Westmont (City) 60559 (Zip Code)

County: DuPage

Telephone Number: (630)323-4400 **Fax #** (630)323-4583

IDPA ID Number: 520970446001

Date of Initial License for Current Owners: 05/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name Gary Geise **Telephone Number:** (419)252-5731

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/99 to 05/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Barry Lazarus
(Title) V.P., Director of Reimbursement

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,730	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,730	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	337	1,919	10,575	12,831	8
9	SNF/PED					9
10	ICF	15,716	11,467	620	27,803	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,053	13,386	11,195	40,634	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 71.63%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 6560

Medicare Intermediary Blue Cross of Maryland

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/00 Fiscal Year: 05/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	254,687	27,396	1,964	284,047	1,234	285,281	0	285,281			1
2	Food Purchase		165,568		165,568		165,568	(107)	165,461			2
3	Housekeeping	104,974	13,964	534	119,472		119,472	0	119,472			3
4	Laundry	42,878	19,483	1,682	64,043		64,043	0	64,043			4
5	Heat and Other Utilities			132,908	132,908	14,659	147,567	0	147,567			5
6	Maintenance	29,850	17,418	36,966	84,234		84,234	0	84,234			6
7	Other (specify): Medical Waste			265	265		265	0	265			7
8	TOTAL General Services	432,389	243,829	174,319	850,537	15,893	866,430	(107)	866,323			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000	0	18,000			9
10	Nursing and Medical Records	1,952,123	263,655	54,342	2,270,120	19,846	2,289,966	286	2,290,252			10
10a	Therapy	406,186	3,612	94,022	503,820		503,820	0	503,820			10a
11	Activities	83,445	2,667	2,910	89,022		89,022	(27)	88,995			11
12	Social Services	69,640			69,640		69,640	0	69,640			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Progra	2,511,394	269,934	169,274	2,950,602	19,846	2,970,448	259	2,970,707			16
	C. General Administration											
17	Administrative	92,438		318,247	410,685	(62,704)	347,981	0	347,981			17
18	Directors Fees							0				18
19	Professional Services			21,676	21,676	(21,676)		0				19
20	Dues, Fees, Subscriptions & Promotions			85,731	85,731		85,731	(18,610)	67,121			20
21	Clerical & General Office Expense	204,640	32,305	685,881	922,826	21,676	944,502	(631,295)	313,207			21
22	Employee Benefits & Payroll Taxes			506,756	506,756	1,653	508,409	0	508,409			22
23	Inservice Training & Education			3,760	3,760		3,760	0	3,760			23
24	Travel and Seminar			9,125	9,125		9,125	0	9,125			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			101,253	101,253		101,253	0	101,253			26
27	Other (specify): Per Pur. 454, Other 923			1,377	1,377		1,377	(454)	923			27
28	TOTAL General Administration	297,078	32,305	1,733,806	2,063,189	(61,051)	2,002,138	(650,359)	1,351,779			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,240,861	546,068	2,077,399	5,864,328	(25,312)	5,839,016	(650,207)	5,188,809			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			284,895	284,895	25,312	310,207	0	310,207			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			(286)	(286)		(286)	0	(286)			32
33	Real Estate Taxes			76,437	76,437		76,437	0	76,437			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			40,520	40,520		40,520	0	40,520			35
36	Other (specify):*							0				36
37	TOTAL Ownership			401,566	401,566	25,312	426,878		426,878			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		316,777	35,183	351,960		351,960	0	351,960			39
40	Barber and Beauty Shops		1,655	18,731	20,386		20,386	0	20,386			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			85,096	85,096		85,096	0	85,096			42
43	Other (specify):* IV Drugs		142,794		142,794		142,794	0	142,794			43
44	TOTAL Special Cost Centers		461,226	139,010	600,236		600,236		600,236			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,240,861	1,007,294	2,617,975	6,866,130	0	6,866,130	(650,207)	6,215,923			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(107)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,841)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	286	10		10
11	Discounts, Allowances, Rebates & Refunds	(27)	11		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(545)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(454)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(615,331)	21		24
25	Fund Raising, Advertising and Promotional	(18,610)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,328)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (650,207)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (650,207)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS — **Page 5A**

Facility Name Manorcare at Westmont
IDO# 0019489
Report Period Beginning: 06/01/99
Ending: 05/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(107)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	(107)	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	(9,841)	21	**Line 5**	0
6	**Rented Facility Space**	0	0	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	0
8	**Laundry for Non-Patients**	0	0	**Line 8**	(107)
9	**Non-Straightline Depreciation**	0	0	**Line 9**	0
10	**Interest and Other Investment Income**	286	10	**Line 10**	286
11	**Discounts, Allowances, Rebates & Refunds**	(27)	11	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	(27)
13	**Sales Tax**	(545)	21	**Line 12**	0
14	**Non-Care Related Interest**	0	0	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	(454)	27	**Line 15**	0
17	**Non-Care Related Fees**	0	0	**Line 16**	(739)
18	**Fines and Penalties**	0	0	**Line 17**	0
19	**Entertainment**	0	0	**Line 18**	0
20	**Contributions**	(1,250)	21	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	0	**Line 20**	(18,610)
22	**Special Legal Fees & Legal Retainers**	0	0	**Line 21**	(626,997)
23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	0
24	**Bad Debt**	(615,331)	21	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(18,610)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	(454)
29	**Non-Paid Workers**	0	0	**Line 28**	(646,957)
30	**Donated Goods**	0	0	**Line 29**	(643,939)
31	**Amortization Expense**	0	0	**Line 30**	0
32				**Line 31**	0
33				**Line 32**	0
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	0
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(643,939)
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Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(107)	0	0	0	0	0	0	0	0	0	0	(107)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(107)	0	0	0	0	0	0	0	0	0	0	(107)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	286	0	0	0	0	0	0	0	0	0	0	286	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(27)	0	0	0	0	0	0	0	0	0	0	(27)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	259	0	0	0	0	0	0	0	0	0	0	259	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(18,610)	0	0	0	0	0	0	0	0	0	0	(18,610)	20
21	Clerical & General Office Expenses	(626,967)	0	0	0	0	0	0	0	0	0	0	(626,967)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(454)	0	0	0	0	0	0	0	0	0	0	(454)	27
28	**TOTAL General Administration**	(646,031)	0	0	0	0	0	0	0	0	0	0	(646,031)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(645,879)	0	0	0	0	0	0	0	0	0	0	(645,879)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(645,879)	0	0	0	0	0	0	0	0	0	0	(645,879)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe Manorcare at Westmont # 0015489 Report Period Beginning 06/01/99 Ending: 05/31/00

Show Pgs 6A thru

Show Pgs 6E thru 6I

Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corporation of America	Toledo, OH			
		(SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

Sum_6

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
V	Sec Page	Home Office Allocation	$ 218,247	HCR Manorcare, Inc	100.00%	$ 218,247	$	1
V	9							2
V								3
V								4
V	10a	Therapy Management	35,184	Heartland Management Services	100.00%	35,184		5
V								6
V								7
V								8
V								9
V								10
V								11
V								12
V								13
Total			$ 353,431			$ 353,431	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule V

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginnin 06/01/99 Ending: 05/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending:)5/31/00

VIII. ALLOCATION OF INDIRECT C

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: HCR ManorCare, Inc.
Street Address: 333 N. Summit St.
City / State / Zip Code: Toledo, OH 43604-2617
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Accumulated Cost	#########	357 Nurs.Fac.	$ 388,478	$ 221,496	318,247	$ 1,234	1
2	5	Utilities	Accumulated Cost	#########	357 Nurs.Fac.	4,614,666		318,247	14,659	2
3	10	Nursing	Accumulated Cost	#########	357 Nurs.Fac.	6,247,503	4,177,723	318,247	19,846	3
4	17	General & Administrative	Accumulated Cost	#########	357 Nurs.Fac.	80,443,795	26,746,978	318,247	255,543	4
5	22	Employee Benefits	Accumulated Cost	#########	357 Nurs.Fac.	520,233		318,247	1,653	5
6	30	Depreciation	Accumulated Cost	#########	357 Nurs.Fac.	7,968,019		318,247	25,312	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 100,182,694	$ 31,146,197		$ 318,247	25

Print Preview

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	82,819	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	79,174	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,645)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	80,082	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	76,437	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	75,706	8
	1996	75,833	9
	1997	77,313	10
	1998	78,875	11
	1999	79,470	12

Line 2 = $39,738 for '98 + $39,736 for '99.

Line 4 = $39,735 (2nd 1/2 of $79,470) for Jul.-Dec. 1999 + $33,775 for Jan.-May 2000 + $6,572 adjustment for prior year

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,334 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1977	$ 195,699	1
2					2
3	TOTALS			$ 195,699	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1977	$ 1,372,073	$ 35,585		$ 35,585	$	$ 815,554	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	CURRENT YEAR DEPRECIATION					134,921		134,921		635,878	9
10				1985	42,165						10
11				1986	9,808						11
12				1987	118,541						12
13				1988	118,593						13
14				1989	58,768						14
15				1990	15,910						15
16				1991	58,674						16
17				1992	84,338						17
18				1993	50,656						18
19				1994	739,724						19
20				1995	184,192						20
21	UPGRADE BATHROOM			1996	7,522						21
22	WALLVINYL/DRYWALL/PAINT			1996	9,318						22
23	CARPET/FLOORING			1996	8,542						23
24	VENT. CONTROL SYSTEM			1996	10,697						24
25	UPGRADE LAUNDRY			1996	4,948						25
26	INSTALL ELECTRIC UNIT HEATER			1996	1,171						26
27	CAPITALIZED LABOR			1996	7,272						27
28	ELECTRICAL			1996	2,060						28
29	RENOVATE 2ND FLOOR			1996	2,532						29
30	LANDSCAPING			1996	3,719						30
31	ELECTRICAL			1996	5,391						31
32	REMODEL SHOWER ROOMS			1996	16,274						32
33	ROOFING			1996	20,818						33
34	DECORATING/WALLCOVERINGS			1996	5,129						34
35	RETILE STORAGE UNIT			1996	1,463						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 170,506		$ 170,506	$	$ 1,451,432	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	NURSE CALL SYSTEM			1996	3,109						9
10	CONSTRUCT STONE WALL			1996	1,500						10
11	HVAC			1996	13,997						11
12	PLUMBING			1997	3,795						12
13	SECURITY SYSTEM			1997	2,914						13
14	INSTALL TILE			1997	11,920						14
15	INSTALL WATER HEATER			1997	2,404						15
16	RECEIVER SYSTEM			1997	1,642						16
17	REMODEL RESTROOM			1997	3,626						17
18	NURSES STATION WORK			1997	4,981						18
19	ROOFING			1997	5,656						19
20	ROOM UPGRADES			1997	6,450						20
21	HVAC			1997	10,230						21
22	ASPHALT/CONCRETE WALK			1997	5,180						22
23	RETIREMENTS			1987	(88,726)						23
24	RETIREMENTS			1992	(11,376)						24
25	CARPET			1997	9,621						25
26	ELECTRICAL/LIGHTING			1997	3,560						26
27	CABINETRY & COUNTERTOPS			1997	12,771						27
28	RENOVATE UTILITY ROOMS			1997	13,000						28
29	INSTALL NEW DOORS			1997	5,519						29
30	FIRE ALARM PANEL			1997	2,316						30
31	INSTALL TILES			1997	15,000						31
32	DIESEL GENERATOR			1997	36,196						32
33	PROFESSIONAL FEES			1997	2,276						33
34	RENOVATIONS			1997	6,924						34
35	RENOVATIONS - CARPENTRY			1997	12,615						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	COMPRESSOR			1997	3,237						9
10	FACILITY PLAN ALLOC.			1997	2,759						10
11	ASPHALT & CONCRETE WORK			1997	5,180						11
12	SIDEWALK & FENCE WORK/REPAIRS			1997	2,395						12
13	DECORATING			1997	1,150						13
14	ELECTRICAL			1998	836						14
15	HVAC WORK			1998	560						15
16	PLUMBING			1998	2,934						16
17	CARPET			1998	622						17
18	PAINTING/WALLCOVERING			1998	38,975						18
19	PLUMBING			1998	11,610						19
20	eLECTRICAL			1998	41,203						20
21	DEVELOPERS			1998	7,300						21
22	fLOORING/CEILING			1998	21,486						22
23	LIGHT FIXTURE			1998	673						23
24	HVAC			1998	2,611						24
25	DOOR/WINDOW			1998	10,656						25
26	SIGN			1998	11,914						26
27	CARPENTRY			1998	55,367						27
28	MILLWORK			1998	6,043						28
29	FINISH STUDS			1998	28,900						29
30	GENERAL REQUIREMENT			1998	11,534						30
31	FUNDATION WORK			1999	229						31
32	BUILDING IMPROVEMENTS			1999	2,952						32
33	ELECTRICAL			2000	4,668						33
34	FIRE RATE CEILING			2000	890						34
35	RETIREMENTS			2000	(196,153)						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 938,378	$ 114,389	$ 114,389	$		$ 583,644	37
38	Current Year Purchases	64,002						38
39	Fully Depreciated Assets	(66,529)						39
40	Home Office Allocation			25,312	25,312			40
41	TOTALS	$ 935,851	$ 114,389	$ 139,701	$ 25,312		$ 583,644	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 284,895	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 310,207	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 25,312	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,035,076	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 40,520 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	2,964	hrs	$ 78,634	26	$ 630	$ 1,820	2,990	$ 81,084	1
2	Licensed Speech and Language Development Therapist	10a	1,024	hrs	30,273	230	5,739		1,254	36,012	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	2,836	hrs	75,704	19	471	1,792	2,855	77,967	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,2		# of prescrpts				316,777		316,777	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): X-Ray & Lab	39,3					35,183			35,183	13
14	TOTAL				$ 184,611	275	$ 42,023	$ 320,389	7,100	$ 547,023	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 85,928	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (227,136))	1,337,634		3
4	Supply Inventory (priced at)	14,449		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,887		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,441,898	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	195,699		13
14	Buildings, at Historical Cost	3,137,929		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	935,851		16
17	Accumulated Depreciation (book methods)	(2,035,076)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	3,834		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,238,237	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,680,135	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 168,549	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	112,736		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,029		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,510		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Trade Payable & Liabilities	39,741		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 428,565	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 428,565	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,251,570	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,680,135	$	48

***(See instructions.)**

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Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,473,253	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,473,253	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	382,263	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 382,263	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(5,603,946)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (5,603,946)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,251,570	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/99 Ending: 05/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,233,172	1
2	Discounts and Allowances for all Levels	(2,005,975)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,227,197	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,634,182	6
7	Oxygen	743	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,634,925	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,562	12
13	Barber and Beauty Care	16,221	13
14	Non-Patient Meals	107	14
15	Telephone, Television and Radio	9,841	15
16	Rental of Facility Space		16
17	Sale of Drugs	321,752	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,166	19
20	Radiology and X-Ray	1,684	20
21	Other Medical Services		21
22	Laundry	12,646	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$ 373,979	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc. $2,904 Purchase Discount $27**	2,931	28
28a	**Late Charges**	9,361	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,292	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 7,248,393	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 850,537	31
32	Health Care	2,950,602	32
33	General Administration	2,063,189	33
	B. Capital Expense		
34	Ownership	401,566	34
	C. Ancillary Expense		
35	Special Cost Centers	515,140	35
36	Provider Participation Fee	85,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,866,130	40
41	**Income before Income Taxes (line 30 minus line 40)****	382,263	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 382,263	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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